

identity when comparing oats with wheat using a double diffusion technique with a rabbit antigliadin serum," for this did occur when the strength of buffer was increased. In another publication¹³ Elton and Ewart did demonstrate an antigenic relationship of wheat to barley, oats, and maize. Other workers^{14,15} have also shown an antigenic similarity between wheat, rye, barley, and oats prolamines. Dr. Dissanayake and his colleagues also state that barley is known to be harmful. I would be interested to know what conclusive experimental proof provided the basis for this remark, especially as many centres continue to allow their coeliac patients to ingest barley in the belief it is not harmful.

Finally, their results seem to show that in some patients a reduction in jejunal enzyme levels and a decrease in surface: volume ratios of repeat jejunal biopsy specimens occurred after the oats challenge. Perhaps these changes would have reached statistical significance if more oats had been given, or for a longer time, and have supported the conclusion of Dicke *et al.*¹⁶ that "wheat flour and rye flour and oats have a very unfavourable effect on the patient."—I am, etc.,

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SIR,—Dr. A. S. Dissanayake and his colleagues (26 October, p. 189) found that four adult patients with coeliac disease did not develop jejunal mucosal damage after eating oats for four weeks. This is inadequate to justify their conclusion that "oats are harmless to coeliac subjects and can be included in a gluten-free diet." The same authors previously reported a study on 38 coeliac patients whom they had followed up for two years before concluding that the degree of mucosal recovery in coeliac patients is dependent on the strictness of gluten exclusion.¹ Why should not the same standard be applied to an investigation on the place of oats in the coeliac diet? It is possible that if these four subjects had continued to take oats for a longer period of time the average decreases that occurred in the surface: volume ratios of jejunal biopsy specimens, and in the disaccharidase levels, might have

reached the conventional levels of statistical significance. It is known that steatorrhoea may take several weeks to develop² after gluten ingestion but faecal fat estimations were not included in the study.

Coeliacs have good reasons to suspect that oats may be harmful for the following reasons. (1) Dicke, who discovered the treatment of coeliac disease, proved in one of his experiments that oats alone could produce steatorrhoea.³ (2) Oats and barley, as well as wheat and rye, are excluded in most Continental and North America gluten-free diets, and the draft world-wide standard for gluten-free foods of the Codex Alimentarius Commission excludes the gluten of all four cereals. (3) In a survey on the first 1,000 members of the Coeliac Society 17.7% of the 373 adults and 11.7% of the parents of 395 children who replied stated that they found that they were upset by oats.⁴ (4) Insufficient is known about the cause of the complication of malignancy in coeliac disease, and this alone is sufficient reason for the exclusion of oats unless it can be completely exonerated in fully comprehensive and long-term experiments.—I am, etc.,

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New Alternatives in the N.H.S.

SIR,—While it is right to consider ways in which doctors and others who work in the Health Service could help to economize by avoiding unnecessary duplication of equipment and facilities and by switching off taps and lights which are not required (2 November, p. 272), one should not forget the waste which occurs on account of the huge administrative machine which runs the service. The Service has undergone an administrative explosion with little noticeable improvement in efficiency.

Measures which could be taken centrally to economize might include central bulk buying of frequently used constructional materials such as laminate instead of each individual contractor placing a separate and much smaller order. Another example is the specifications which emanate from the Department of Health and Social Security for such items as bedside lockers; these specifications are often irrelevant and expensive.

While we as doctors should behave responsible over the possibility of wasting resources, the fault does not lie entirely with us by any means.—I am, etc.,

PAUL R. J. VICKERS

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SIR,—In one N.H.S. hospital last week a difficult major abdominal operation was performed, quite skilfully, by the Egyptian registrar. The consultant surgeon was repairing the hydraulic spring hinge on the theatre door, all other efforts to get this dangerously

faulty mechanism put right over the previous 12 months having failed.

An appeal for expert help was blocked by the secretary to the engineer. She said that he, the assistant engineer, and the hospital engineer were all at a meeting of administrative officers. She said they were usually back from these meetings by 4.30 p.m.—I am, etc.,

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SIR,—I found the reports of the Winchester Conference both informative and stimulating, and I should like to comment on some of the points raised in the third session (16 November, p. 389) regarding general practice.

There are several references to the work of Marsh and McNay,¹ whose conclusions the speakers appear to have accepted, but I should like to challenge what I feel is a fundamental error in this survey of work in general practice. The very title of their papers, "Team Work Load in an English General Practice," was misleading, since throughout the paper work load is constantly equated with consultation rate and there is minimal reference to the multiplicity of non-face-to-face items of service with which the N.H.S. G.P. is all too familiar. Even the delegation of work takes time and the team member to whom the work is given must often report back to the doctor or present work for checking or signing.

My own experience suggests that the increased delegation of work to the team allows a little more time to be given to those patients who need it, but at the same time uncovers a good deal more of the iceberg of patient demand. As a result I find that my working day is now very much more concentrated than it was 10 or more years ago.

When I first read Marsh and McNay's papers I feared that their conclusions might lead to just those comments that appeared in your report—that is, that with an improved primary health care team the G.P. could manage a list of 10,000 patients. No doubt the Department of Health and Social Security is delighted with such a conclusion.

Dr. Olsen (p. 394) commented that "an improvement in the quality of general practice would take an enormous load off the outpatient department." Is there any evidence that this is so? I doubt it. And even if it were true there is still a limited amount of medical manpower to deal with an unlimited patient demand, and shifting the load from one section of the profession to another will not solve the problems that face us. Whatever measures may be tried to deal with the problems of the N.H.S. we must be careful not to build on shaky foundations.—I am, etc.,

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Respiratory Distress Syndrome in the Newborn

SIR,—In your leading article on this subject (23 November, p. 428) you refer to our recent paper on "Improved Prognosis of Infants Mechanically Ventilated for Hyaline